EMERGENCY MEDICAL CARE COMMITTEE MEETING AGENDA

Thursday, November 19th, 2026, at 8:30 A.M.
2995 McMillan Ave, Ste #178, San Luis Obispo

MEMBERS
CHAIR (July 1st, 2026 - June 30th, 2027)
Chris Javine, *Pre-hospital Transport Providers, 2026-2030*
VICE – CHAIR (July 1st, 2026 - June 30th, 2027)
Matt Bronson, *City Government, 2024-2028*

Alexandra Kohler, *Consumers, 2024-2028*
Jonathan Stornetta, *Public Providers, 2024-2028*
Michael Talmadge, *EMS Field Personnel, 2024-2028*
Jay Wells, *Sheriff's Department, 2024-2028*
Candice Monge, *Hospitals*, *2026-2028*
Michele Brimer, *MICNs*, *2026-2030*
Dr. Stefan Teitge M.D., *Emergency Physician, 2026-2030*
Brandy Marquardt, *Consumers*, *2026-2030*
Dr. Brad Knox M.D., *Physician*, *2026-2030*

EX OFFICIO
Ryan Rosander, *EMS Director*
Dr. Bill Mulkerin M.D., *EMS Medical Director*
Suzanne Jed, *Director of Public Health*

STAFF
Maya Craig-Lauer, *PHEP Representative*
Rachel Oakley, *EMS Coordinator*
Eric Boyd, *EMS Coordinator*
Kaitlyn Blanton, *EMS Coordinator*
Vacant, *Administrative Assistant*

AGENDA	ITEM	LEAD
Call To Order	Introductions Public Comment	C. Javine
Action/Discussion	Approval of minutes: July 16th 2026, Minutes (*attached)*	C. Javine
Action/Discussion	**Membership Discussion** • Welcome new EMCC Members • Confirmation of new Clinical Sub-Committee members	R. Rosander
Action/Discussion	**Policy Revision:** • 220 Ambulance Triage to Waiting Room • 153 Trauma Patient Triage and Destination • 706 Hemorrhage Control, Tourniquet, Hemostatic Dressings • 652 Obstetric Emergencies – Eclampsia, Pre-Eclampsia, Severe Hypertension • 653 Obstetric Emergencies – Postpartum Hemorrhage • 212 Tiered Response Program for Skilled Nursing Facilities	R. Rosander K. Blanton W. Mulkerin
Action/Discussion	**Policy Attachment Revisions:** • 153 Attachment A • 212 Attachment A • 212 Attachment B	K. Blanton W. Mulkerin
Staff Reports	• Health Officer • EMS Agency Director Report • EMS Medical Director Report • PHEP Staff Report	S. Jed R. Rosander B. Mulkerin M. Craig-Lauer
Committee Members' Announcements or Reports	Opportunity for Board members to make announcements, provide brief reports on their EMS-related activities, ask questions for clarification on items not on the agenda, or request consideration of an item for a future agenda (Gov. Code Sec. 54954.2[a][2])	Committee Members
Adjourn	**Next Meeting: January 21st, 2027**	C. Javine

Emergency Medical Care Committee

DRAFT Meeting Minutes
8:30 AM July 16th, 2026
2995 McMillan Way, Suite 178
San Luis Obispo, CA 93401

MINUTES

MEMBERS PRESENT:
Chair Chris Javine, Pre-Hospital Transport Providers
Alexandra Kohler, Consumers
Jay Wells, Sheriff's Department
Bob Neumann, Consumers
Rachel May, Emergency Physicians
Jonathan Stornetta, Public Providers
Julia Fogelson, Hospitals
Michael Talmadge, EMS Field Personnel
Brad Knox, Physicians

MEMBERS ABSENT:
Diane Burkey, MICNs
Jonathan Stornetta, Public Providers
Matt Bronson, City Government

EMS AGENCY STAFF PRESENT:
Rachel Oakley, EMSA
Eric Boyd, EMSA
Alyssa Vardas, EMSA
Kaitlyn Blanton, EMSA
Maya Craig-Lauer, PHEP

PUBLIC COMMENTORS:
Dennis Rowley, Cal Star
Rob Jenkins, CALFIRE
Erin Nash-Fairfax

EX OFFICIO:
Bill Mulkerin, EMSA
Ryan Rosander, EMSA

1. CALL TO ORDER

Chair Chris Javine called the meeting to order at 8:32 a.m.

2. REVIEW AND APPROVAL OF January 15th, 2026, and May 21st MINUTES

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Minutes Michael Talmadge moved to approve the minutes with corrections, Jay Wells is second to approve, all approved, no opposition.

The EMCC meeting in July covered introductions, approval of January and May minutes with amendments, and updates to Policy 153 on trauma mission triage and destination. Key changes include aligning trauma activation criteria with Sierra Vista's in-house standards, reducing scene times, and simplifying criteria for field providers. Discussions highlighted the need for updated 2021 guidelines to improve triage accuracy and reduce under-triage. The meeting also addressed the transition of EMS agency roles and upcoming training sessions.

3. Protocols/Policies for Review:

153 Trauma Patient Triage and Destination

Discussion:

It was brought up that we should be looking at the 2021 ACS guidelines, including things like crush injuries, falls 10 feet, abdominal bruising, extremely amputation.

Discussed how it can be difficult to match the field trauma steps to what is done in the hospital.

It was mentioned that this was done in collaboration with the trauma team at the trauma hospital.

There was a clarification in the attachment that breathe should be breaths.

Discussed that having too many steps can contribute to confusion of field providers.

Next Steps:

Coordinate with Sierra Vista's trauma program and other relevant stakeholders to review the proposed changes to Policy 153 (including ACS 2021-based triage elements and tourniquet use), refine the policy based on their input, and bring the updated version back to EMCC for discussion before it goes live in the end-of-year update class.

Policy has been tabled until next meeting.

4. STAFF REPORTS/ANNOUNCEMENTS

Health Officer Update – The County is currently searching for a new Health Officer.

EMS Director Update – R. Rosander discussed upcoming trainings; the MHOAC training, and the Investigations training. We will have a new app coming in August.

EMS Medical Director Update - Dr. Mulkerin – mentioned the upcoming mid-year update training on August 4th and 6th.

PHEP Program Manager Update - Maya discussed the updates made to County Health Plans:

The Health Continuity of Operations Plan, Crisis and Emergency Risk Communication and Joint Information Center Plan, and the Pandemic and Influenza Plan.

5. FUTURE AGENDA ITEMS

6. ADJOURNMENT

Action:

Chair Javine adjourned the meeting at 9:20 a.m.

MEETING DATE	Novemeber 19, 2026
STAFF CONTACT	Ryan Rosander, Director of EMS 805.788.2512 rrosander@co.slo.ca.us
SUBJECT	Ambulance Triage to Waiting Room
SUMMARY	The County of San Luis Obispo Emergency Medical Services Agency has developed Policy #220: Ambulance Triage to Waiting Room in response to ongoing challenges with emergency department patient volumes and prolonged ambulance patient offload times (APOT). These delays affect hospital operations and reduce ambulance availability for subsequent emergency responses. The policy establishes a standardized process that allows clinically appropriate, stable patients to be transferred directly to an emergency department waiting room or designated triage area after evaluation and formal acceptance of care by an authorized hospital healthcare professional. This effort is intended to support both receiving hospitals and transporting agencies by improving patient flow, reducing unnecessary ambulance offload delays, and returning ambulances to service sooner. The policy provides hospitals with additional flexibility in managing emergency department capacity while maintaining patient safety and continuity of care. This collaborative approach aims to improve operational efficiency, strengthen coordination between hospitals and transporting agencies, and preserve emergency medical response capabilities throughout San Luis Obispo County.
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff
RECOMMENDED ACTION(S)	Recommend Policy #220: Ambulance Triage to Waiting room, for approval by EMCC, and move to the 2026 EMS Update Class agenda:
ATTACHMENT(S)	Policy #220: Ambulance Triage to Waiting room

POLICY #220: Ambulance Triage to Waiting Room

I. PURPOSE

A. To establish criteria for safely triaging appropriate ambulance-transported patients to a receiving hospital emergency department (ED) waiting room or designated triage area while maintaining continuity of care and timely ambulance availability within the County of San Luis Obispo.

II. POLICY

A. Eligible patients may be directed to ED waiting room triage on arrival or during an offload delay. A 30-minute delay is not required before considering this option. Patient safety and clinical assessment shall take priority over ambulance availability or ED crowding.

B. Placement shall occur only after an ED registered nurse (RN) or other licensed ED healthcare professional authorized to accept patient care evaluates the proposed placement and accepts the transfer of care. The goal is to complete the transfer of care within 15 minutes of ambulance arrival at the receiving hospital. The receiving hospital determines the appropriate patient location and assumes responsibility for ongoing ED triage, reassessment, and care after acceptance.

C. EMS personnel shall continue care until the patient is physically transferred off the EMS gurney, a verbal report is provided, and the receiving ED professional acknowledges acceptance and signs for transfer of care. Transfers not completed under this policy shall follow SLOEMSA Policy #158: Ambulance Patient Offload Time (APOT) Monitoring.

III. PATIENT ELIGIBILITY — ALL CRITERIA REQUIRED

A. No chief complaint, assessment finding, or clinical trend suggesting a need for immediate or time-sensitive intervention or a significant risk of deterioration.

B. Alert, cooperative, oriented, GCS 15, and able to communicate changes in condition. A minor must be accompanied by a parent/guardian or responsible caregiver who remains with the patient.

C. At least two sets of clinically stable vital signs, including a set near hospital arrival, appropriate for age and baseline, without concerning trends. Adult reference ranges: HR 50–120/min; SBP 100–180 mmHg; RR 10–24/min; SpO_2 ≥94% on room air. Values outside these ranges do not automatically exclude a patient when consistent with their documented baseline, with concurrence of the receiving ED RN or other licensed ED healthcare professional authorized to accept patient care and documented clinical rationale.

D. Able to maintain a seated position safely, with baseline mobility or wheelchair use, without substantial fall risk, continuous supervision, or loss of dignity.

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E. No need for continuous cardiac or respiratory monitoring, supplemental oxygen, IV access, IV fluids, or ongoing ALS treatment. Existing IV access may be discontinued when clinically appropriate, but not solely to qualify for waiting room placement. Administration of isolated non-sedating medications, such as ondansetron, does not automatically exclude an otherwise eligible patient when reassessment confirms clinical stability.

IV. EXCLUSION CRITERIA

A. Potential acute coronary syndrome, stroke, sepsis, shock, respiratory distress, significant trauma or uncontrolled bleeding, concerning syncope, active labor/obstetric emergency, or any other potentially time-critical condition.

B. Altered mental status, impaired decision-making from intoxication, acute psychiatric or behavioral emergency, suicidal/homicidal ideation, involuntary psychiatric hold, gravely disabled status, patients under conservatorship requiring supervision that cannot be safely provided in the waiting room, or law enforcement custody.

C. Unable to sit safely; requires a stretcher, isolation or ongoing close observation not available in the waiting area; or an unaccompanied minor without an appropriate caregiver.

V. PROCEDURE

A. At hospital notification or upon arrival, EMS personnel shall identify potential eligibility for waiting room triage and present the patient to the ED RN or other licensed ED healthcare professional authorized to accept patient care. A verbal report shall include the chief complaint, pertinent history, two sets of vital signs, treatments provided, response to care, and identified risks.

B. Following acceptance of patient care by the ED RN or other authorized licensed ED healthcare professional, EMS personnel shall safely transfer the patient to a hospital chair, wheelchair, or designated waiting room/triage area. The receiving clinician's transfer-of-care signature shall be obtained after the patient is physically transferred off the EMS gurney. A registration clerk, security officer, or unattended waiting area is not an acceptable receiving party.

C. If the patient deteriorates before transfer, resume indicated care and notify the ED RN or other licensed ED healthcare professional authorized to accept patient care immediately. When eligibility is disputed, or ED personnel are unable to accept the patient, continue EMS care, consult the ED charge RN and EMS field supervisor, and follow Policy #158: Ambulance Patient Offload Time (APOT) Monitoring, including 30-minute APOD escalation.

VI. DOCUMENTATION

A. In the ePCR, document the assessment supporting waiting room triage, serial vital signs, patient location, receiving clinician’s name/title and signature, verbal handoff, and time of completed physical transfer of care. Record APOT accurately under

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Policy #158: Ambulance Patient Offload Time (APOT) Monitoring, and document any exception, refusal, delay, or change in condition.

VII. AUTHORITY

- California Health and Safety Code, Division 2.5
- California Code of Regulations, Title 22, Division 9

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

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MEETING DATE	December 19th, 2026
STAFF CONTACT	Kaitlyn Blanton, EMS Coordinator kblanton@co.slo.ca.us
SUBJECT	Trauma Triage Steps and Trauma Procedures New Obstetric Protocols and related formularies Tiered Response Program
SUMMARY	**Policy #153 and #153 - Attachment A**, have been updated from the 2017 version in partnership with The American College of Surgeons (ACS) Committee on Trauma (COT) guidelines and San Luis Obispo County's Trauma Center, receiving guidance from their Trauma Medical Director and Trauma Program Manager. Additions to the current Trauma Triage Steps are intended to expand San Luis Obispo County's current field activation criteria as well as better align itself with the Trauma Tiers utilized in-house at the San Luis Obispo County Trauma Center. Implementation is intended to ensure optimal patient outcomes across the continuum of care. Definitions have been simplified to reduce confusion among EMS providers regarding transportation expectations. All Medical Direction remains within San Luis Obispo County. Previous versions have gone through continued revision and review since last going through EMCC in July of 2026. SLOEMSA will continue to monitor best practices and how they can be implemented in future versions with the partnership of both the San Luis Obispo County level III trauma center, and the Level II trauma center in Santa Maria, CA. **Procedure #706** After the October Tri-County Trauma Advisory Committee meeting, minor areas were identified across the tri-counties in ways that the LEMSA trauma policies can better align themselves. Second tourniquet placement was not addressed in SLOEMSA internal policies. They have been updated to include the appropriate use of 2nd tourniquet placement. As we continue moving San Luis Obispo County forward with the shared goal of improving patient care, SLOEMSA is working towards introducing two new protocols for field EMS providers: **Protocol #652 – Obstetric Emergencies: Eclampsia, Pre-eclampsia, and Severe Hypertension and Protocol #653 – Obstetric Emergencies: Postpartum Hemorrhage.** With the addition of Magnesium Sulfate to the County formulary in early 2026, EMS providers now have an expanded ability to provide evidence-based care to patients experiencing obstetric emergencies. These protocols reflect current best practices identified by the June 2026 EMDAC Medical Advisory Committee and incorporate ACOG recommendations where applicable to the EMS setting.

	Protocol #650 has been updated with new early transport blood pressure parameters to be identified by BLS providers, reference to Protocol #653, and updated cord cutting and clamping. **Policy #212 Tiered Response Program for Medical Facilities** has been updated to allow for a broader range of facilities to utilize for code 2 ambulance-only response, pending they meet all requirements and are approved by SLOEMSA. Decision-maker for the request shall be an MD/DO, NP, or PA, although the caller may initiate call on their behalf. New language in policy should allow for interested/appropriate urgent cares, memory care facilities, county jail, and homeless shelters that have on-site medical staff to utilize this policy. Additionally, a Corrective Action Plan section has been added to allow SLOEMSA the ability to review participants and their use of Policy #212. **Attachment A** has been updated with new language in effort to reduce inappropriate Code 2 responses as well as **Attachment B** with the addition of the audit form to serve as internal documentation for facilities placed on a Corrective Action Plan.
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff
RECOMMENDED ACTION(S)	Recommended the following for approval by EMCC Policy #153 and #153 Attachment A Procedure #706 Policy #652, #653, Magnesium Sulfate Formulary, Midazolam Formulary, TXA Formulary, Lidocaine Formulary Protocol #650 Policy #212, #212 Attachment A, and #212 Attachment B
ATTACHMENT(S)	Policy #153 and #153 Attachment A Procedure #706 Policy #652, #653, Magnesium Sulfate Formulary, Midazolam Formulary, TXA Formulary, Lidocaine Formulary Protocol #650 Policy #212, #212 Attachment A, and #212 Attachment B

POLICY #153: TRAUMA PATIENT TRIAGE AND DESTINATION

I. PURPOSE

A. To establish guidelines for EMS personnel to identify and transport "significantly injured" patients who could benefit from the rapid response and specialized services of a trauma center.

II. ~~SCOPE~~

~~A. This policy applies to both adult and pediatric injured patients, unless stated otherwise.~~

III. PROCEDURE

A. Trauma Activation Criteria

1. "STEP 1, STEP 2, STEP 3 TRAUMA ALERT" - Patient meeting any one of the Physiologic (Step 1) and/or Anatomic criteria (Step 2) and/or Mechanism of Injury (Step 3) following a traumatic event shall be designated a "TRAUMA ALERT" and shall be transported to the closest trauma center. The target off-scene time should be 10 minutes or less for transport personnel.

~~2. "STEP 3 TRAUMA CONSULTATION" - Patient meeting (Step 3) Mechanism of Injury - contact with the County of San Luis Obispo (SLO) Trauma Center for patient destination. The target off-scene time should be 10 minutes or less for transport personnel.~~

3. "STEP 4 TRAUMA CONSULTATION" - A trauma consultation with the County of San Luis Obispo Trauma Center shall be made to determine patient destination when a paramedic identifies a significantly injured patient who does **not** meet Step 1 (Physiologic), Step 2 (Anatomic), or Step 3 (Mechanism of Injury) criteria, but meets one or more Step 4 (Special Patient or System Considerations) criteria.

    a. If an out of county trauma center is closer and is the intended destination, no destination consult with the County of San Luis Obispo Trauma Center is necessary. Proceed to out of county trauma center and update in accordance with this policy.

~~B. Trauma Patient Criteria~~

~~1. Patients meeting any one of the Physiologic and/or Anatomic and/or Mechanism of Injury criteria following a traumatic event shall be a "TRAUMA ALERT" and transported to the closest trauma center. Patient meeting Mechanism of Injury and/or Special Patient/System Considerations shall be a "TRAUMA CONSULT" and contact the County of SLOTrauma Center for patient destination, unless the patient's intended destination is already a Trauma Center.~~

C. Medical Direction

1. All Base Hospital requests and/or orders, regardless of trauma center destination, shall be made to the County of San Luis Obispo Trauma Center.

D. Closest Trauma Center

The closest Trauma Center for patients being transported within San Luis Obispo County will be defined as follows:

a. A unit on scene of a call that is located within San Luis Obispo County south of El Campo Rd should proceed to ~~Marian Regional Medical Center~~ the closest Santa Barbara County Trauma Center.

b. A unit on scene of a call that is located within San Luis Obispo County north of El Campo Rd should proceed to ~~Sierra Vista Regional Medical Center~~ the County of San Luis Obispo Trauma Center.

c. In any other area west or east of El Campo Rd, crews should exercise discretion in determining which trauma center is closest or fastest for patient transport.

d. Discretion in all cases should include abnormal traffic patterns, congestion, or other travel factors affecting transport to the closest and fastest Trauma Center

1. **STEP 1 (Physiologic Criteria)**

The target off-scene time should be 10 minutes or less for transport personnel

Adult Injured patients meeting any one of the following criteria:

a. Glasgow Coma Scale ≤13 (based on patient history attributed to injury)
b. Systolic blood pressure <90mmHg
c. Respiratory rate <10 or >29 breaths per minute

Pediatric injured patients (≤34 Kg) meeting any one of the following:

a. Glasgow Coma Scale ≤ 13 (based on patient history and attributed to injury)
b. Evidence of poor perfusion – color, temperature, etc.
c. Respiratory rate
    1. >60 breaths per minute or respiratory distress
    2. <20 breaths per minute in infants <1year
d. Heart rate
    1. ≤5 years (<22Kg) heart rate <60 beats per minute or >180 beats per minute
    2. ≥6 years (23-34Kg) heart rate <60 beats per minute or >160 beats per minute
e. Blood pressure
    1. Newborn (<1 month) systolic blood pressure <60mmHG
    2. Infant (1 month – 1 year) systolic blood pressure <70mmHg
    3. Child (1 year to 10 years) systolic blood pressure <70mmHg + 2X age in years
    4. Child (11-14 years) systolic blood pressure <90mmH

2. **STEP 2 (Anatomic Criteria)**

The target off-scene time should be 10 minutes or less for transport personnel

Injured patients meeting any one of the following criteria:

a. All significant penetrating injuries to head, neck, torso and extremities proximal to knee or elbow
b. Chest wall instability or deformity (e.g. flail chest)
c. Two proximal long bone fractures (above the elbows and knees)
d. Mangled, degloved, crushed, or pulseless extremity
e. Open or depressed skull fracture
f. Paralysis or suspected spinal cord injury with new onset motor or sensory deficits
g. Pelvic injury with high-risk mechanism of injury (motor vehicle collisions, auto vs. pedestrian accidents, motorcycle collisions, falls from heights)
h. Any extremity amputation excluding digits or phalanges
i. Abdominal bruising from seat belt (lap seatbelt sign)
j. Strangulation w/ hard signs (voice changes, bruising, discoloration, subcutaneous emphysema, crepitus)
k. Active bleeding requiring a tourniquet or wound packing with continuous pressure

3. **STEP 3 (Mechanism of Injury Criteria)**

The target off-scene time should be 10 minutes or less for transport personnel

Injured patients meeting any one of the following criteria:

a. Falls
    1. Adults: ~~>20 feet~~ >10 feet (one story is equal to 10 feet)
    2. Pediatric: (≤34 Kg) >10 feet (one story is equal to 10 feet) OR 2x the child's height
b. High-risk auto crash
    1. Passenger Space Intrusion (PSI) of space: >12 inches occupant patient site; or >18 inches anywhere within the passenger space
    2. Ejection (partial or incomplete) from automobile
    3. Death in the same vehicle
c. Auto vs. pedestrian/bicyclist thrown, run over, or with significant impact (>20 mph)
d. Motorcycle or unenclosed transport vehicle crash (>20 mph)
e. Near hanging with fall or jump associated ("Judicial Hanging")
f. Pediatric ages 0-9 unrestrained or improperly restrained (MVC)

4. **STEP 4 (Special Patient or System Considerations)**

Age and co-morbid considerations

Injured patients meeting any one of the following criteria:

a. EMS provider judgement
b. Age greater than 65 or less than 14 years (>65 or <14)
c. Pregnancy > 20 weeks

d. Burns with mechanism

e. Vehicle accident with prolonged extrication or patient entrapment

f. Submersion event/Drowning with high suspicion or confirmed trauma

g. Anticoagulation therapy (excluding aspirin) or other bleeding disorders with head injury (excluding minor injuries)

NOTE: a "TRAUMA CONSULT" is not required for ground/low level impact falls with GCS ≥ 14 or when GCS is normal for patient

E. Trauma Center Contact

1. Contact the receiving trauma center early and immediately upon determining the patient meets trauma patient triage criteria with a "TRAUMA ALERT" or "TRAUMA CONSULTATION"

2. "TRAUMA ALERT"

a. A "TRAUMA ALERT" is initiated by ALS personnel when an injured patient meets any one of the Step 1 (Physiologic) or Step 2 (Anatomic) or Step 3 (Mechanism of Injury) Criteria. Consider early notification to the intended receiving trauma center~~,~~ notify from the scene when possible.

~~b. EMS personnel should provide a "TRAUMA ALERT" early and from the scene when possible to assist in early activation of the trauma team and determination of patient destination.~~

~~c. ALS personnel must contact the trauma center with the TRAUMA ALERT.~~

d. A "TRAUMA ALERT" report should include the following:

1. "TRAUMA ALERT" meeting trauma triage step criteria "x"
2. Unit and paramedic #
3. ETA to trauma center
4. Report on individual patient (MIVT format):

- Age and sex
- Mechanism of injury and scene
- Injury and complaint
- Vital signs including GCS
- Treatment and response
- Include specific triage findings or considerations that identify the patient as meeting TRAUMA ALERT criteria.

3. TRAUMA CONSULTATION

a. "TRAUMA CONSULTATION" with the ~~SLO County~~ County of San Luis Obispo Trauma Center should be obtained to determine trauma patient destination when ~~Step 3 (mechanism(s) of injury) criteria or~~ Step 4 (special considerations) are present and Step 1 (Physiologic), Step 2 (Anatomic), and Step 3 (Mechanism of injury) criteria are NOT met and the closest patient destination is NOT already a designated trauma center.

b. Only ALS personnel may request a "TRAUMA CONSULTATION" for patient destination.

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c. A "TRAUMA CONSULTATION" report should include the following:

1. "TRAUMA CONSULTATION" meeting trauma triage step 4 criteria
2. Unit and paramedic #
3. ETA to Trauma Center and ETA to closest ED ~~(When a trauma center is the closest facility, include that information in radio report).~~
4. Report on the individual patient (MIVT format):
   - Patient age and sex
   - Mechanism of injury and scene
   - Injury and complaints
   - Vital signs including GCS
   - Treatment and response
   - Include specific findings or considerations that identify the patient as meeting TRAUMA CONSULTAION criteria.
5. Paramedic concerns

4. When the San Luis Obispo County Trauma Center is not receiving the patient but has had contact with the transporting unit, the Trauma Center shall notify the receiving hospital of the incoming patient and provide that hospital with any prehospital care ~~patient~~ information, including any Base Hospital orders given.

5. When practical, a brief updated report should be given to the ~~trauma center~~ receiving Hospital by ALS personnel and include any significant changes in route in vital signs, GCS, physical findings, symptoms or treatments.

6. All Base Hospital orders or requests shall be made to the ~~SLO County~~ County of San Luis Obispo Trauma Center, regardless of destination.

F. Exceptions to Direct Transport to a Trauma Center

Trauma patients will be transported to the closest ED in the following situations:

1. Patient condition deteriorates and ~~necessitates transport to the closest ED, such~~ presents as the following:

   a. Unmanageable airway (Intubation and/or SGA attempts are unsuccessful and an adequate airway cannot be maintained with BVM or other BLS devices).

   b. Uncontrollable bleeding with rapidly deteriorating vital signs.

   c. Traumatic cardiac arrest – see ~~EMS Agency Prehospital Determination of Death/Do Not Resuscitate (DNR) End of Life Care Policy #125~~ EMS Agency Policy #125: Prehospital Determination of Death/Do Not Resuscitate (DNR) End of Life Care.

2. Direct destination order from San Luis Obispo County Trauma Center

3. When a transport unit is directed to an alternate hospital regardless of patient presentation per Incident Command/ Designee (Transportation Unit Leader) during an MCI – see EMS Agency Policy #210: Multi-Casualty Incident Response Plan.

4. Patient refusal - see ~~EMS Agency~~ EMS Agency ~~Patient Refusal of Treatment and/or Transport~~ Policy #203: Patient Refusal of Treatment and/or Transport.

5. Trauma center is on complete diversion – see ~~EMS Agency Hospital Diversion~~

~~Policy #154: Hospital Diversion.~~ EMS Agency Policy #154: Hospital Diversion.

6. If the County of San Luis Obispo Trauma Center is on partial diversion, patients meeting Trauma Triage Criteria shall still be accepted by the Trauma Center and shall be transported accordingly – see EMS Agency Policy #154: Hospital Diversion.

7. Utilization of EMS helicopters for the response/transport of trauma patients ~~must be in accordance with~~ – see EMS Agency Policy #155: EMS Helicopter Operations.

IV. AUTHORITY

- California Health and Safety Code, Division 2.5
- California Code of Regulations, Title 22, Division 9

V. ATTACHMENTS

A. Trauma Triage Matrix

IV. Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

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TRAUMA ALERT CRITERIA – transport to nearest TC

STEP 1 - Physiologic

TARGET DEPART SCENE ≤ 10 Min

Adult Criteria

- Glasgow Coma Scale ≤ 13
- Systolic blood pressure <90 mmHg
- Respiratory rate <10 or > 29 breaths per minute

Pediatric Criteria

- Glasgow Coma Scale≤ 13
- Evidence of poor perfusion – color, temperature, etc.
- Respiratory Rate
  - > 60/min or respiratory distress/apnea
  - < 20/min in infants < 1 yr
- Heart Rate
  - ≤ 5 yrs (<22 kg) < 80 or > 180/min
  - ≥ 6 yrs (23-34 kg) < 60 or > 160/min
- Blood Pressure
  - Newborn (<1 month) SBP < 60mmHg
  - Infant (1mo to 1 yr) SBP <70 mmHg
  - Child (1yr to 10 yrs) SBP < 70mmHg + 2X age in yrs
  - Child (11 to 14 yrs) SBP < 90 mmHg

STEP 2 – Anatomic

TARGET DEPART SCENE ≤ 10 MIN

- All penetrating injuries to head, neck, torso, and extremities proximal to the elbow or knee
- Chest wall instability or deformity (i.e. flail chest)
- Two long bone fractures – proximal to elbow or knee
- Mangled, degloved, crushed or pulseless extremity
- Open or depressed skull fracture
- Paralysis or suspected spinal cord injury with new onset motor or sensory deficits
- Pelvic injury with high-risk mechanism of injury
- Any extremity amputation excluding digits or phalanges
- Abdominal bruising from seatbelt (lap seatbelt sign)
- Strangulation with hard signs (voice changes, bruising, discoloration, subcutaneous emphysema, crepitus)
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

STEP 3 – Mechanism

TARGET DEPART SCENE ≤ 10 MIN

- Falls
  - Adults - > ~~20~~ 10 feet (one story equals 10 feet)
  - Children (≤34Kg) - > 10 feet OR 2x the child's height
- High risk auto crash
  - Intrusion of passenger compartment space > 12 inches occupant site or > 18 inches any site including the roof/floor
  - Ejection (partial or complete) from automobile
  - Death in the same vehicle
- Auto vs pedestrian/bicycle thrown, run over, or with significant impact (> 20 mph)
- Motorcycle or unenclosed transport vehicle crash > 20 mph
- Near hanging with jump or fall associated ("Judicial Hanging")
- Pediatric ages 0-9 unrestrained or improperly restrained (MVC)

If STEPS 1, 2 & 3 not applicable – continue to STEP 4

TRAUMA CONSULT CRITERIA –

Call for "destination orders" unless already transporting to a TC

STEP 4 – Special Patient and System Considerations

- EMS provider judgement
- Age > 65 yrs or < 14 yrs
- Pregnancy > 20 weeks
- Burns with traumatic mechanism
- Vehicle accident with prolonged extrication or patient entrapment
- Submersion event/Drowning with high suspicion or confirmed trauma
- Anticoagulants therapy * (excluding ASA) or other bleeding disorders with head injury (excluding minor injuries)

(*) Trauma Consult is not required for ground level/low impact falls with a GCS ≥ 14 (or GCS is normal for patient) – follow EMS Agency Policy # 151 Destination

Contact TC and Transport to nearest ED with:
-Unmanageable airway
-Uncontrolled bleeding
-Traumatic Arrest

If ALL STEPS not applicable – follow EMS Agency Policy #151 Destination

HEMORRHAGE CONTROL/TOURNIQUET/HEMOSTATIC DRESSINGS

ADULT	PEDIATRIC (≤34 KG)

BLS

- Universal Protocol #601
- Hemorrhage control
  - Direct Pressure
  - Tourniquet application – see notes below
  - Hemostatic dressing – for uncontrolled hemorrhage after all above measures fail

BLS Optional

Pulse Oximetry – O_2 administration per Airway Management Protocol #602

ALS Standing Orders

Hypotension – See General Trauma Protocol #660

Base Hospital Orders Only

- Tourniquet removal – see notes below
- As needed

Notes

- Indications for tourniquet application
  - Life threatening, persistent hemorrhage that cannot be controlled by other means
- Contraindications for tourniquet use
  - Non-extremity hemorrhage
  - Proximal extremity (junctional) locations where tourniquet application is not practical
- **TOURNIQUET (TQ) APPLICATION - BLS**
  - Visually inspect injured extremity and avoid placement of tourniquet over joint, angulation or open fracture, stab/penetrating or gunshot wound sites
  - Assess and document circulation, motor and sensation distal to injury site
  - Apply approved tourniquet proximal to wound (usually 2-4 inches) per manufacturer recommendations
  - Tighten tourniquet rapidly to least amount of pressure required to stop bleeding and/or distal pulses are affected
  - Cover wound with appropriate clean/sterile dressing/bandage
  - DO NOT cover tourniquet – keep visible
  - Re-assess and document absence of bleeding distal to tourniquet
  - Remove any improvised tourniquets that may have been applied after approved tourniquet is applied
  - Document time of placement **ON** the tourniquet device
  - If the first tourniquet- tightened as much as possible- does not control the bleeding, apply second tourniquet
    - Apply second tourniquet above the first tourniquet (proximal to torso)
    - Do not place second tourniquet over joint, angulation or open fracture, stab/penetrating or gunshot wound sites
    - Tighten second tourniquet fully until bleeding completely stops. Never remove or loosen either tourniquet unless ALS Base Hospital consult has determined otherwise.
  - Inform receiving facility and personnel of tourniquet placement and time of placement

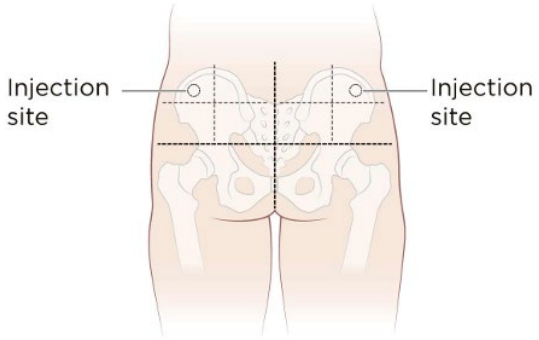
- **TOURNIQUET REMOVAL – ALS with Base Hospital consult only**
  - When the ALS personnel on scene determine:
    - The tourniquet was inappropriately or improperly placed
    - The tourniquet may no longer be necessary
  - PROCEDURE FOR TOURNIQUET REMOVAL
    - Obtain IV access
    - Monitor ECG
    - Maintain firm pressure over wound for minimum of 5 minutes before releasing
    - Slowly release tourniquet and monitor for reoccurrence of bleeding
    - Document time of release
    - Bandage, reassess and document circulation, motor and sensation distal to the wound site
- **HEMOSTATIC DRESSING USE –** <u>requires additional training by provider agency</u>
  - If bleeding persists for greater than 3 min despite using all other measures for control, apply approved hemostatic dressing directly to the bleeding site according to manufacturer's direction
  - Replace absorbent pad/pressure dressing
  - Apply direct pressure and/or replace tourniquet per manufacture's recommendation
  - Approved tourniquet and hemostatic dressings listed in #706 Attachment-A

OBSTETRIC EMERGENCIES: ECLAMPSIA, PREECLAMPSIA, SEVERE HYPERTENSION

ADULT	PEDIATRIC (≤34 KG)
BLS	
• **Universal Protocol #601** • Pulse Oximetry - O2 administration per Airway Management Protocol #602	
ALS	
Severe Hypertension/Preeclampsia • **Magnesium Sulfate** 4Gm in 100mL NS IV over 10 minutes if: o More than 20 weeks gestation or up to 6 weeks post-partum o SBP ≥140-159 or DBP ≥90-109 mmHg <u>combined with</u> any of the following: ▪ Severe headache ▪ Blurred vision ▪ RUQ pain or Epigastric pain **OR** o SBP ≥160mmHg or DBP ≥110mmHg **If unable to obtain IV access:** • **Magnesium Sulfate** 10Gm IM o To lessen discomfort in a non-seizing patient– <u>TWO</u> 2.5Gm IM injections in EACH buttock for a TOTAL of 5Gm per buttock **Eclampsia (Active Seizure)** • **Midazolam** 5mg IV/IM **Plus:** • **Magnesium Sulfate** 4Gm in 100mL NS IV over 10 minutes **If unable to obtain IV access:** • **Magnesium Sulfate** 10Gm IM o 5Gm in each buttock	
Base Hospital Orders Only	
• As needed	• As needed
Notes	

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- Mainstay treatment for preeclampsia and eclampsia is Magnesium Sulfate. The majority of eclamptic seizures resolve quickly on their own and do not typically last longer than 5 minutes.
    - If a patient is still actively seizing upon arrival of EMS, accounting for dispatch to arrival time, an EMS witnessed seizure is likely meeting status epilepticus criteria.
    - If the eclamptic seizure is resolved before ALS treatment has begun, still continue with Magnesium Sulfate administration.
- Check blood pressure frequently – at least every 10 minutes
- Eclampsia and Preeclampsia can affect patients up to 6 weeks post-partum
- For IM injection - consider mixing 20 mg of 2% Lidocaine (see Lidocaine formulary) with 10 Gm of Magnesium Sulfate due to volume of injection that may cause pain or discomfort.
- For Magnesium Sulfate IM injections:



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OBSTETRIC EMERGENCIES: POST-PARTUM HEMORRHAGE CONTROL

ADULT	PEDIATRIC (≤34 KG)
BLS	
• **Universal Protocol #601** • Pulse Oximetry ○ O2 administration per Airway Management Protocol #602 • Post-Partum Hemorrhage control ○ Perform visual exam to determine site of bleeding ○ For perineal tear (external vaginal area), apply direct pressure to the perineum with sterile dressings. DO NOT place dressings inside the vagina ○ Firmly massage fundus	
ALS	
• **Normal Saline** up to 500mL IV ○ May repeat X1 to maintain SBP > 90 If immediate post-partum hemorrhage persists despite use of available measures: • **TXA** 1Gm in 100mL NS IV infusion over 10 minutes ○ Must be within 3 hours post-delivery	
Base Hospital Orders Only	
• As needed	• As needed

Notes

- Immediate Post-Partum Hemorrhage is significant or ongoing bleeding after delivery. Defined as the loss of 1000mL or more of blood up to 24 hours after delivery, or any blood loss accompanied by signs or symptoms of hypovolemia
- Clinical manifestation of blood loss may be delayed until considerable blood loss has occurred in post-partum hemorrhage patients. Consider early fluid resuscitation as indicated under Universal Protocol #601

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CHILDBIRTH

NORMAL	COMPLICATIONS
BLS	

• Universal Protocol #601
• Pulse Oximetry
  - 02 administration per Airway Management Protocol #602
 	
Delivery
 	
• Patient assessment with visual exam of perineum for crowning
• Control head and speed of delivery
• Check for cord around neck
  ○ Avoid pre-delivery cord clamping
• Deliver upper, then lower shoulder
• Dry, stimulate, and wrap baby
• Suction airway as needed
• If condition of mother or newborn requires emergent resuscitation (e.g., infant is non-vigorous or mother is having significant hemorrhage) immediately clamp and cut the cord 6" from newborn's umbilicus.
• For vigorous full-term newborn, deferred cord clamping and cutting 30-60 seconds during newborn skin-to-skin is appropriate.
• Healthy infant to mother's breast
• Prepare for delivery of placenta
 	
Postpartum Hemorrhage Control
 	
• Perform visual exam to determine site of bleeding
• For perineal tear, apply direct pressure
• Firmly massage fundus
• For ongoing/uncontrolled hemorrhage or hemodynamic instability refer to **Protocol #653 Obstetric Emergencies: post-partum Hemorrhage**
	• Universal Protocol #601
	• Pulse Oximetry
	  - 02 administration per Airway Management Protocol #602
	
	Initiate Transport Early
	
	• Hypertension BP SBP ≥160 or DBP ≥110 mmHg
	• Seizures — follow Seizure Protocol #620
	• Vaginal bleeding in last trimester not associated with labor may indicate Placenta Previa/Abruptio
	• Breech/Limb presentation
	• Prolapsed cord – Place mother in knee-chest position. Feel cord for pulse. With gloved hand, push baby into vagina slightly to take pressure off cord. Maintain this position. Do not attempt to push cord back
	
	Newborn Viability
	
	• Gestation ≤20 weeks without signs of life (pulseless, not breathing) are not considered viable. Resuscitation may be withheld by first responder
	  - If gestational age is uncertain – initiate resuscitation and contact nearest Base hospital
	  - Provider judgement of scene may also warrant initiation of resuscitation efforts in gestation of ≤ 20 week newborn
	  - If resuscitation initiated - contact nearest Base Hospital

ALS Standing Orders	
• Refer to appropriate protocol based on patient's presentation	• Refer to appropriate protocol based on patient's presentation
Base Hospital Orders Only	
• As needed	• As needed

Notes



- Knee-chest position for prolapse cord presentation (above)
- General guideline transport in left lateral position Obtain Para/Gravida
- Refer to policy #125 for withholding resuscitation on pre-term fetal delivery ≤ 20 weeks gestation.
- If delivery of neonate with gestational age ≤ 20 weeks without resuscitation efforts, transport of post-partum patient is still encouraged. Use OB-kit swaddle/blanket for transport of neonate with mother.
- If resuscitation of gestational age ≤ 20 weeks is initiated, continue with newborn resuscitation per protocol #641 with early base hospital notification and rapid transport.

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Magnesium Sulfate

Classification: Electrolyte, Anticonvulsant, CNS Depressant

Actions:

1. Blocks peripheral neuromuscular transmission by reduction of acetylcholine release
2. Reduces striated muscle contraction

Indications:

1. Status asthmaticus unresponsive to beta-antagonists or anticholinergics
2. SOB due to COPD exacerbation or asthma
3. Severe hypertension or pre-eclampsia in pregnancy
4. Eclampsia

Contraindications:

Heart blocks – can slow cardiac conduction through the AV node

Acute MI

Hypotension

Hypermagnesemia

Precautions:

Renal Insufficiency
Recent History of MI

Adverse Effects:

Hyporeflexia (decreased reflexes)	Diaphoresis
AV Block/Complete Heart Block	Itching/Rash
Bradycardia	Drowsiness
Respiratory Depression – *see notes*	Facial Flushing

Administration:

ADULT DOSE

Refractory in Severe Respiratory Distress and Bronchospasm:

2 Gm IV in normal saline over 20 minutes

- Mixing Instructions: Give 1 Gm in 100 mL normal saline over 10 minutes with immediate repeat for a **total** dose of 2 Gm over 20 minutes
- May repeat once 5 minutes after initial dose has been completed

Severe Hypertension/Preeclampsia

4 Gm in 100mL NS IV over 10 minutes if:

- More than 20 weeks gestation and up to 6 weeks post-partum
- SBP ≥140-159 or DBP ≥90-109 mmHg combined with any of the following:
  - Severe headache
  - Blurred vision
  - RUQ pain or Epigastric pain

OR

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- SBP ≥160mmHg or DBP ≥110mmHg
  - **If unable to obtain IV access:** 10 Gm IM – 5Gm in each buttock
  - To lessen discomfort in non-seizing patients– TWO 2.5Gm IM injections in EACH buttock for a TOTAL of 5Gm per buttock

Eclampsia (Active Seizure)
4 Gm in 100mL NS IV over 10 minutes

- **If unable to obtain IV access:** 10 Gm IM – 5Gm in each buttock

~~**Pregnant patients or up to 6 weeks post-partum presenting with active seizure (concern for eclampsia)** – Contact Base Hospital for Magnesium Sulfate 4 Gm IV in normal saline over 20 minutes~~

- ~~Mixing instructions: Give 2 Gm in 100 mL normal saline over 10 minutes with immediate repeat for a **total** dose of 4 Gm over 20 minutes~~

PEDIATRIC DOSE
Refractory in Severe Respiratory Distress and Bronchospasm:
50mg/kg max of 2Gm
Repeat doses – base order only
Mixing instructions: appropriate weight-based dosing of ≤ 1 Gm in 100 mL of NS over 20 minutes. If patient appropriate weight-based dose is > 1 Gm, administer 1 Gm in 100 mL NS over 10 minutes followed by remaining Magnesium Sulfate in additional 100 mL bag over 10 minutes. TOTAL should not exceed 2 Gm

Onset: IV - immediate

Duration: IV - 30-60 minutes

Notes:

- Respiratory depression is more likely with a too-fast IV infusion rate - ensure proper drip rate
- If patient presents with hyporeflexia, discontinue Magnesium Sulfate immediately
- If overdose is suspected consult with Base Hospital immediately to give Calcium Chloride to reverse effects.
- Magnesium Sulfate Overdose Indications:
  - New onset altered mental status
  - New onset of cardiac rate and rhythm changes
  - Respiratory depression
  - Hyporeflexia (Indicated by decreased or loss of deep tendon reflexes)

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MIDAZOLAM (Versed®)

Classification: Benzodiazepine

Actions:

1. Hypnotic, amnesiac, sedative, anticonvulsant
2. Potent but short-acting, 3-4 times more potent than diazepam
3. Has NO effect on pain

Indications:

1. Active, continuous seizure
2. Status epilepticus
3. Sedation prior to cardioversion
4. Acute behavior disorder (agitated patient danger to self or others)
5. Severe muscle spasms (base physician order only)
6. Eclampsia

Contraindications (Relative):

1. **History of hypersensitivity to benzodiazepines**
2. **Shock with depressed vital signs**
3. **ALOC of unknown etiology / polypharmacy ingestion**
4. **Narrow-angle glaucoma**
5. **Pregnant patients NOT actively seizing**
6. ~~**Eclampsia (Base Hospital order only)**~~

Adverse Effects (Precautions, Side Effects and Notes):

Midazolam may cause respiratory depression and/or hypotension especially if administered rapidly. Monitor patient closely.

1. Common side effects include drowsiness, hypotension, respiratory depression and apnea. These are more likely to occur in the very young and the very elderly. Rarely, patients may experience paradoxical agitation.
2. Respiratory depression is more likely in patients who have taken other CNS depressant drugs such as opioids, alcohol, other benzodiazepines or barbiturates, or when given rapidly.
3. Midazolam is metabolized in the liver and excreted by the kidneys. **Doses should be adjusted accordingly in patients with underlying hepatic or renal diseases or cardiac diseases with low flow states such as CHF.**
4. GI effects include nausea, vomiting, hiccough/hiccup
5. Pain at injection site (IV/IM), intranasal irritation if given IN

Administration:

ADULT DOSE

1. **Seizure**:
   - 5 mg SLOW IV or
   - 5 mg IM or IN (split dose between nares)

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- **May repeat once after 5 minutes for persistent or recurrent seizures**

2. **Agitated patient sedation** (danger to self or others):
   - Up to 5 mg SLOW IV
   - 5 mg IM or IN (IN split dose between nares)
   - **May repeat once after 5 minutes for significant agitation / threat to self or others**

3. **Pre-cardioversion sedation**:
   - Up to **2 mg** SLOW IV
   - 5 mg IM or IN (IN split dose between nares)
   - **May repeat once after 10 minutes**

*****EKG, Pulse oximetry, and ETCO2 (when equipment is available) monitoring will be used at all times.**

PEDIATRIC DOSE

1. **Seizure**
   - 0.2 mg/kg SLOW IV not to exceed 5 mg
   - 0.2 mg/kg IM/IN not to exceed 5 mg
   - **May repeat once after 5 minutes for persistent or recurrent seizures**
   - **Not to exceed 5 mg TOTAL**
2. **Agitated Patient Sedation**:
   - Up to 0.2 mg/kg not to exceed 5 mg
   - Up to 0.2 mg/kg IM/IN not to exceed 5 mg
   - **May repeat once after 5 minutes for significant agitation/threat to self or others**
   - **Not to exceed 5 mg TOTAL**

(IN **volume** for pediatric patient up to 1ml per nostril)
Pediatric maximum **volume** of one (1) mL per nostril per atomization (0.2-0.3 mL per nostril is ideal)

- volumes > 1 mL are more likely to saturate the mucosal surface causing medication runoff into the proximal pharynx

3. **Pre-cardioversion:**
   - 0.1 mg / kg IN or SLOW IV.
   - **Max 2mg**

*****EKG, Pulse oximetry, and ETCO2 (when equipment is available) monitoring will be used at all times.**

Onset: 1.5 - 5 minutes IV
2 - 6 minutes IN

15 minutes IM

Duration: 2 - 6 hours for IV/IN/IM

LIDOCAINE (Xylocaine®)

Classification: Antidysrhythmic agent

Action: Suppresses ventricular ectopy by stabilizing the myocardial cell membrane.

Indications:

1. Cardiac arrest with ventricular fibrillation or pulseless ventricular tachycardia
2. Post conversion or defibrillation of ventricular rhythms with base contact.
3. Ventricular tachycardia with pulse present
4. Symptomatic/malignant ventricular ectopy
5. Pain Management following IO Placement
6. Pain Management for IM injections with Magnesium Sulfate for Preeclampsia and Eclampsia

Contraindications:

1. **2° degree type II heart block**
2. **3° degree heart block**
3. **Junctional bradycardia**
4. **Ventricular ectopy associated with bradycardia**
5. **Idioventricular rhythm**
6. **Known allergy to Lidocaine or sensitivity to other anesthetics (report to base).**

Adverse Effects:

Cardiovascular
Bradycardia
Hypotension
Arrest
Blurred vision

Respiratory
Dyspnea
Depression
Apnea

Gastrointestinal
Nausea/vomiting

Neurological
Dizziness
Drowsiness
Paresthesia
Restlessness
Slurred speech
Disorientation
Seizures
Lightheadedness
Tinnitus
Muscle twitching

Administration:

ADULT DOSE

1. **V-Fib/pulseless V-Tach (with SLOEMSA Authorization):** 1.5 mg/kg IVP/IO, repeat every 3-5 minutes, not to exceed 3 mg/kg.
2. **V-Tach with a pulse (with SLOEMSA Authorization):** 1.5 mg/kg IVP, may repeat with 0.75 mg/kg IVP every 5-10 minutes, not to exceed 3 mg/kg.
3. **Pain Management following IO Placement:** 0.5mg/kg (total max dose of 40mg) slow IO push over 60 seconds.

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4. **Pain Management for IM injections in Preeclampsia or Eclampsia:** 20mg 2% Lidocaine (mixed into 10 Gm Magnesium Sulfate for IM injection)

PEDIATRIC DOSE

1. **V-Fib/pulseless V-Tach (with SLOEMSA Authorization):** 1 mg/kg IVP/IO**.** May repeat every 5 minutes, not to exceed 3 mg/kg.
2. **V-Tach with a pulse (with SLOEMSA Authorization):** 1 mg/kg IVP/IO, may repeat with 0.5 mg/kg IVP/IO every 5-10 minutes, not to exceed 3 mg/kg.
3. **Pain Management following IO Placement:** 0.5mg/kg (total max dose of 40mg) slow IO push over 60 seconds.

Onset: 30 - 90 seconds

Duration: 10 - 20 minutes

Notes:

- Lidocaine may be used as backup to Amiodarone with SLOEMSA authorization (using Policy #205 Attachment C) in cases where Amiodarone stock is unavailable. In cases when Lidocaine is substituted for Amiodarone, the minimum stock of Lidocaine shall mimic the same numbers as Amiodarone.
- In cases of premature ventricular contractions, assess need and treat underlying cause. Needs include: chest pain, syncope, R on T situations, multifocal and paired PVCs, bigeminy and trigeminy, and PVCs at 6-12 per minute. See appropriate protocols as needed.
- Lidocaine is to be administered no faster than 50mg/min, except in patients in cardiac arrest.

Tranexamic Acid (TXA) (*Cyklokapron*)

Classification: Antifibrinolytic, plasminogen inactivator

Actions: Reduces fibrinolysis and clot breakdown; stabilizes clot formation; inhibits conversion of plasminogen to plasmin

Indications:
1. Blunt or penetrating traumatic injury with SBP ≤90
2. Significant hemorrhage not controlled by direct pressure, hemostatic agents, or tourniquet application
3. Persistent or uncontrolled post-partum hemorrhage

Contraindications:
- >3 hours post injury
- > 3 hours post birth in cases of post-partum hemorrhage
- Isolated spinal shock
- Isolated head injury
- Non-blood loss conditions
- Isolated extremity hemorrhage when bleeding has been controlled and if there is a strong expectation for re-implantation
- Patients <15 years old
- Active Thromboembolic event (within 24 hrs); i.e. CVA, MI, Pulmonary Embolism, or DVT
- Hypersensitivity or anaphylactic reaction to TXA
- Traumatic Arrest with >5 min of CPR without ROSC
- Drowning or hanging victims

Precautions:
- Severe kidney diseases
- Pregnancy

Adverse Effects: <1%
- **Hypotension** with rapid IV infusion
- Chest tightness, difficulty breathing
- Facial flushing, swelling in hands or feet
- Blurred vision
- Anaphylactoid reaction

Frequency not defined for IV solution
- Headache
- Musculoskeletal pain

Administration:

Adult Dosage (≥15 year old)

1 Gm in 100mL NS IV/IO infused over >10 min

No pediatric dose approved

Pharmacology: Onset: 20 min – 2 hrs
Duration: 2 – 8 hrs

Notes: Rate of administration should not exceed 100 mg/min

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POLICY #: 212 TIERED RESPONSE PROGRAM FOR ~~SKILLED NURSING~~ MEDICAL FACILITIES

I. PURPOSE

A. To establish a process through which ~~skilled nursing~~ medical facilities may participate in a tiered response level for patients requiring unscheduled non-emergent transportation to a hospital.

II. DEFINITIONS

- On-Site Medical Staff – Licensed medical professionals (Physician, Physician's Associate, Nurse Practitioner, or Registered Nurse). ~~staffing a skill nursing facility on a 24 hours per day.~~
- Skilled Nursing Facility (SNF) – A facility that provides healthcare to individuals unable to manage independently in the community and has licensed medical staff on-site twenty four (24) hours per day.
- Medical facility – Any licensed or authorized healthcare facility, clinic, center, office, or other location where medical, nursing, diagnostic, rehabilitative, or other healthcare services are provided. For purposes of this policy, the term "medical facility" does not include hospitals.
- Urgent Care – A medical care facility that is capable of providing prompt medical care, typically for non-life threatening illnesses.

III. POLICY

A. No ~~SNF~~ medical facility will utilize or request tiered response transport unless authorized by the County of San Luis Obispo Emergency Medical Services Agency (~~EMS Agency~~ SLOEMSA) in accordance with this policy.

IV. PROCEDURE

A. A ~~SNF~~ medical facility seeking authorization to participate in the tiered response program must submit a written proposal to the SLOEMSA, which includes the following elements:

1. Requesting facility has a licensed medical staff on duty ~~24 hours per day~~ during operating hours.
2. A written letter of support for the request to participate in the program from the jurisdictional Fire Department and Public Safety Answering Point (PSAP) submit to SLOEMSA.
3. The jurisdictional PSAP must be a SLOEMSA approved Emergency Medical Dispatch provider agency.
4. Requesting facility must provide written documentation detailing process for how staff will handle preparing for the transfer request, including the inclusion

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of appropriate patient transfer documents, and notification of/coordination with receiving hospitals.

5. Final approval may include a review by a SLOEMSA advisory committee(s).

6. SLOEMSA will review each request within sixty (60) days of receipt and will approve request after all requirements have been satisfied:

B. Upon SLOEMSA written approval of request:

1. Approved facility must utilize the Patient Assessment Flow Chart (Attachment A) to determine whether to request a Code 2 or Code 3 response

2. Approved facility will utilize the narrative script (Attachment B, Page 1) when facility contacts the PSAP to request unscheduled patient transport

3. Approved facility will participate in a Quality Improvement (QI) program, and provide documentation to SLOEMSA upon request.

V. CORRECTIVE ACTION

A. The County of San Luis Obispo EMS Agency, at any time, may request and conduct an audit of any participating facility authorized to utilize this policy.

1. Should SLOEMSA determine that continued participation is not appropriate or that the facility has failed to comply with the requirements, procedures, or standards within this policy, SLOEMSA may suspend or revoke a facility's authorization to participate in the tiered response program.

B. Following the determination that a facility has been suspended or revoked, SLOEMSA will develop a corrective action and reinstatement plan.

1. Such plans may include, but are not limited to, additional training, education, competency verification, policy review, operational changes, or other corrective measures deemed necessary.

2. Once a facility has completed all requirements specified by SLOEMSA, reinstated approval will be communicated in writing by SLOEMSA.

3. Facilities who have been reinstated may be subject to extended monitoring as outlined in their corrective action plan.

a. These facilities will be required to fill out page 2 of Attachment B

b. these records must be maintained by the facility for two (2) years.

c. SLOEMSA will determine the length of time a facility needs to complete attachment B, page 2. This will be no less than thirty (30) days and no more than two (2) years.

VI. AUTHORITY

- California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.206, 1797.220, 1797.252, 1798 (a)(b)

VII. ATTACHMENTS

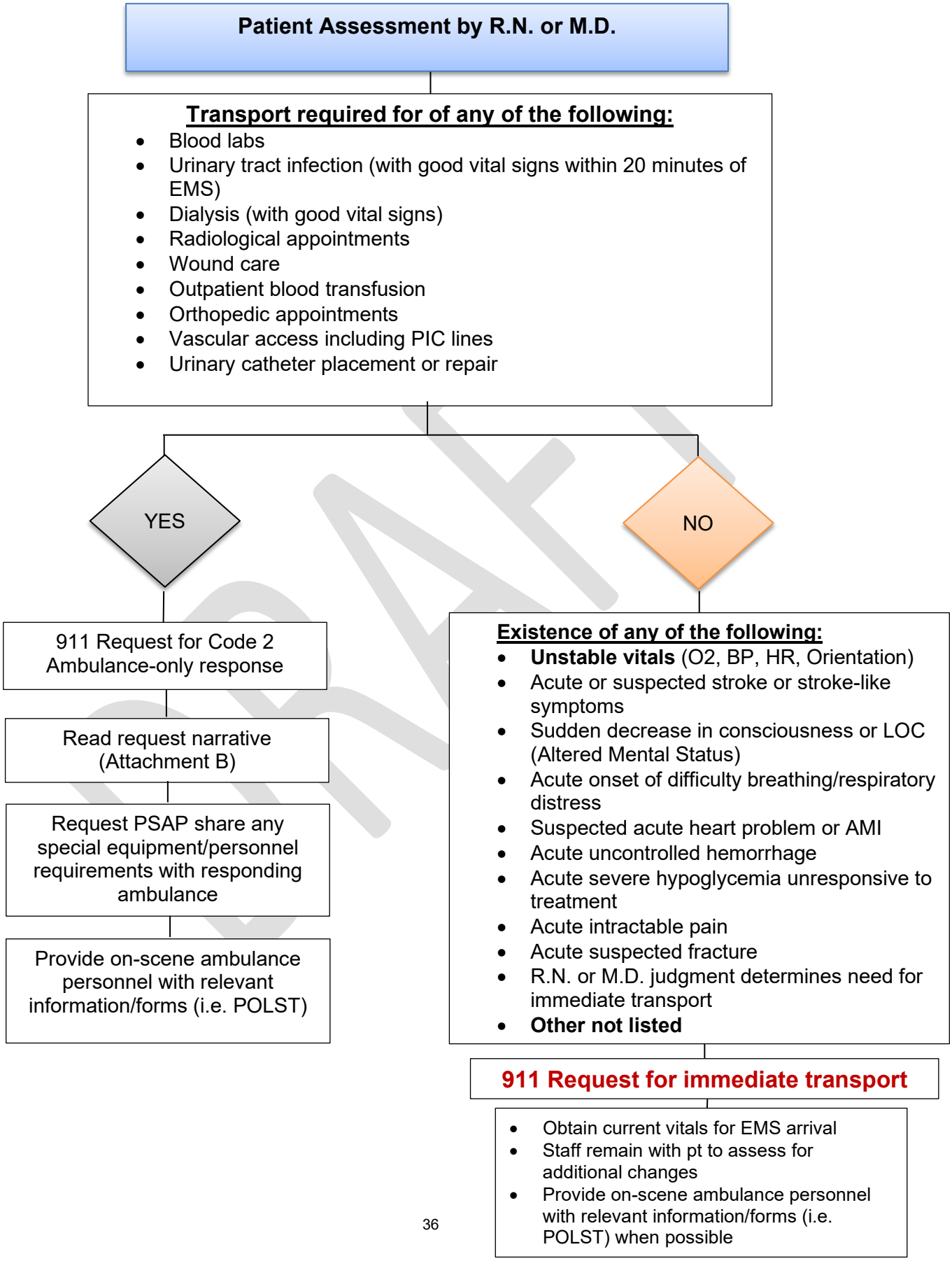
A. Patient Assessment Flow Chart

B. Facility Narrative Script and Corrective Action Plan Audit Form

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

PATIENT ASSESSMENT FLOW CHART



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TIERED RESPONSE PROGRAM FOR MEDICAL FACILITIES
REQUESTING FACILITY NARRATIVE

1) Qualified person (M.D., D.O., N.P., P.A.) has identified the need for code 2 ambulance-only transfer (Attachment A).

2) Dial 911 to initiate the request.

3) State the following:

   "This is _____(Name) from_____ (approved facility name) on behalf of _____(M.D., D.O., N.P., P.A., name - if not the same as caller), requesting a Code 2 Ambulance-only transfer to _____(Hospital)."

4) Monitor patient for changes (see Attachment A) which may require an upgrade to an emergent Code 3 response and dial 911 immediately with updated patient status.

5) Confirm proper transfer documents, including code status / POLST, are properly prepared and ready to deliver to the transport crew.

<u>If your facility is under a Corrective Action plan, please print and fill out page 2 of this form for each Code 2 request</u>. Once your facility Corrective Action Plan has been completed, as communicated by the County of San Luis Obispo EMS Agency, you may disregard page 2.

Please continue to use the script lines 1-5 on page 1 per Policy# 212 when no Corrective Action Plan is in place.

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SLOEMSA Corrective Action Plan Audit Form

Facility Name: _____

Date, Time & Individual making Code 2 Request	Date: _____ Time: _____ Name: _____
Reason for Code 2 Request	
Name of person making Patient assessment	Name: _____ (circle one) M.D. / D.O. / N.P. / P.A. / R.N.
Patient Age & Gender	
Vitals Time Taken: _____	HR: B/P: Oxygen Saturation: Is patient mentation baseline: Y / N
Receiving Facility	

* If facility is on a Corrective Action and Reinstatement plan, fill out the above form in its entirety for each Code 2 Ambulance request. Keep with facility records for two years.